

Chest X-ray Confirmation Form

Please fill out form completely and accurately to confirm delivery of CXR/PACS

Patient Information

Images stored: In PACS On CD On FILM

Facility where X-ray was taken: _____ Contact Number _____

Last name: _____ First name: _____

DOB ____/____/____ TBdb Number _____

Tracking Number _____
(FedEx, UPS, etc.)

Person Requesting Chest X-ray

Date of request ____/____/____

Name of requestor: _____ Contact Number _____

Comments:

Please send chest x-rays to:

Colorado Department of Public Health and Environment

Tuberculosis Program A-3

4300 Cherry Creek Drive South

Denver, CO 80246-1530